Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Continuity of Care Request

Group or Provider Name: _____

Date: _____

This request form and any applicable medical documentation should be sent via secured fax:

(877) 219-9448

Please send one request per fax transmission

Patient Name: Last First MI		**Patient Date of Birth:**
Patient Address: Street City State Zip		
Patient Florida Blue Member Number with Prefix:		
Patient Florida Blue Product: ☐ **BlueCare (HMO)** ☐ **BlueMedicare HMO** ☐ **All Other Florida Blue Products**		
Maternity	**Scheduled Surgery**	**Other Active Treatment**
Date of Most Recent Office Visit:	**Date Last Treated For Condition:**	**Date Last Treated For Condition:**
Expected Delivery Date:	**Date of Most Recent Office Visit:**	**Date of Most Recent Office Visit:**
Obstetrician Name:	**Date of Scheduled Procedure:**	**Diagnosis Code:**
Obstetrician's Florida Blue Provider #:	**Diagnosis Code:**	**Medication/Procedure Code:**
	Procedure Code:	**Estimated Completion Date:**
	Surgeon's Name:	**Provider's Name:**
	Surgeon's Florida Blue Provider #:	**Provider's Florida Blue Provider #:**

Note: An updated request form should be submitted for any changes that need to be made to the original request.